



**MILWAUKEE COUNTY EXECUTIVE  
OFFICE FOR PERSONS WITH DISABILITIES - DECA SUPPLEMENT**

Please complete all sections. Section A is to be completed by the applicant and section B by the physician or counselor. Upon completion, return it to the Office for Persons with Disabilities, 901 N. 9th Street, Room 307-B, Milwaukee, WI 53233. **PLEASE PRINT or TYPE.**

**SECTION - A** (To be completed by the applicant / DECA candidate)

FIRST NAME	M.I.	LAST NAME	SOCIAL SECURITY NUMBER
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The following information is being requested on a voluntary basis. The information will be kept confidential and will be used in accordance with Title I of the ADA (P. L. 101-336). This information is also being requested voluntarily as Milwaukee County is taking affirmative action pursuant to Section 503 of the Rehabilitation Act of 1973.

**A qualified individual is considered disabled if s/he has:**

- (A) a physical or mental impairment that substantially limits one or more of the major life activities of an individual, or
- (B) a record of having such an impairment, or
- (C) being regarded as having such an impairment.

Additionally, the individual should be capable of performing the essential functions of a job when provided with reasonable accommodation.

Do you fit this definition? ☐ Yes ☐ No

If yes, what are your handicapping conditions? \_\_\_\_\_

An individual with a severe disability is one in which the individual is unable to perform, or must have personal assistance in order to perform one or more of the major life activities (self-care, manual tasks, walking, seeing, hearing, speaking, breathing, learning, working, sitting, standing, lifting, thinking, concentrating, and interacting with others).

Do you consider yourself severely disabled? ☐ Yes ☐ No

If Yes, please indicate which major life activities are impacted by your disability.

☐ Self-Care ☐ Manual Tasks ☐ Walking ☐ Seeing ☐ Hearing ☐ Standing ☐ Thinking ☐ Interacting  
☐ Speaking ☐ Breathing ☐ Learning ☐ Working ☐ Sitting ☐ Lifting ☐ Concentrating

What types of personal assistance/equipment do you require? \_\_\_\_\_

What accommodations would you require at the worksite? \_\_\_\_\_

List three (3) areas of occupational interest.

**THE INFORMATION SUPPLIED IS TRUE AND TO THE BEST OF MY KNOWLEDGE.**

Applicant's Signature

Date

I understand and agree, that, as a DECA candidate, I will be placed on a viable list without an actual score or rank and that I will be certified as a DECA eligible for possible appointment without the benefit of test results which are scored and ranked by the Department of Human Resources.

Applicant's Signature

Date

I, \_\_\_\_\_, hereby allow the Milwaukee County Executive Office for Persons with Disabilities to refer my name to other employers (government as well as private sector) for purposes of employment only.

**SECTION - B** (To be completed by Counselor or Physician)

Please verify the disability and any functional limitations for the applicant to the Milwaukee County Disabled Expanded Certification Appointment (DECA) program.

Counselor \_\_\_\_\_ Physician \_\_\_\_\_

Agency/School \_\_\_\_\_ Address \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_

City/State/Zip \_\_\_\_\_ State/Zip \_\_\_\_\_

**NATURE OF DISABILITY:** \_\_\_\_\_

**FUNCTIONAL LIMITATIONS:** \_\_\_\_\_

Please indicate the major life activities which the individual is unable to perform, or must have personal assistance in order to perform.

☐ Self-Care   ☐ Manual Tasks   ☐ Walking   ☐ Seeing   ☐ Hearing   ☐ Standing   ☐ Thinking   ☐ Interacting  
☐ Speaking   ☐ Breathing   ☐ Learning   ☐ Working   ☐ Sitting   ☐ Lifting   ☐ Concentrating

Please indicate the types of personal assistance/equipment that is required. \_\_\_\_\_

**Applicant is able to:**

	Never	Occasionally (1-33%)	Frequently (34-66%)	Continuously (67-100%)
Push/Pull - Seated	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Push/Pull - Standing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bend	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Climb	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Crawl	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Squat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reach above shoulder level	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

	Never	Occasionally	Frequently	Continuously		Never	Occasionally	Frequently	Continuously
<b>LIFT:</b>									
0 - 10#	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11 - 24#	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
25 - 34#	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
35 - 50#	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
51 - 74#	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
75 - 100#	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>CARRY:</b>									
0 - 10#	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11 - 24#	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
25 - 34#	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
35 - 50#	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
51 - 74#	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
75 - 100#	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

	<b>Hours</b>										Continuously	With Rests
Sit	0	1	2	3	4	5	6	7	8	<input type="checkbox"/>	<input type="checkbox"/>	
Stand	0	1	2	3	4	5	6	7	8	<input type="checkbox"/>	<input type="checkbox"/>	
Walk	0	1	2	3	4	5	6	7	8	<input type="checkbox"/>	<input type="checkbox"/>	

	Simple Grasping		Firm Grasp		Fine Manipulation		Push/Pull	
Right	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Left	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Restrictions of Activities:	None	Mild	Moderate	Total
Unprotected heights	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Being around moving machinery	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Exposed to marked temperature changes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Driving automotive equipment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Exposure to dust, fumes, gases	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**OFFICE FOR PERSONS WITH  
DISABILITIES USE ONLY**

DECA Eligible ☐ Yes ☐ No

Date \_\_\_\_\_

Code \_\_\_\_\_

Disability \_\_\_\_\_

Initials \_\_\_\_\_

Counselor/Physician Signature \_\_\_\_\_

Date \_\_\_\_\_